

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040733</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Alden Estates of Evanston</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>2520 Gross Point Road</u> <u>Evanston</u> <u>60201</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(773) 286-3883</u> Fax # <u>(773) 286-3743</u>		(Type or Print Name) <u>Steven M. Kroll</u>	
IDPA ID Number: <u>36-4003478</u>		(Title) <u>Chief Financial Officer</u>	
Date of Initial License for Current Owners: <u>03/15/96</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Estates of Evanston# 0040733 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,330</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>57</u>	Sheltered Care (SC)	<u>57</u>	<u>20,805</u>	5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>98</u>	<u>4,104</u>	<u>6,194</u>	<u>10,396</u>	8
9	SNF/PED					9
10	ICF	<u>1,755</u>	<u>4,358</u>		<u>6,113</u>	10
11	ICF/DD					11
12	SC	<u>49</u>	<u>4,405</u>		<u>4,454</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,902</u>	<u>12,867</u>	<u>6,194</u>	<u>20,963</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 58.01%

D. How many bed-hold days during this year were paid by Public Aid?

none (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/15/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 03/15/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 31 and days of care provided 6,194Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	374,162	14,158		388,320	2,178	390,498		390,498		1
2	Food Purchase		152,921		152,921	(24,910)	128,011	(162)	127,849		2
3	Housekeeping	84,332	23,120		107,452	394	107,846		107,846		3
4	Laundry	37,154	8,480		45,634	51	45,685		45,685		4
5	Heat and Other Utilities			141,479	141,479		141,479	(2,951)	138,528		5
6	Maintenance	49,456		84,161	133,617	1,411	135,028	5,032	140,060		6
7	Other (specify):*										7
8	TOTAL General Services	545,104	198,679	225,640	969,423	(20,876)	948,547	1,919	950,466		8
	B. Health Care and Programs										
9	Medical Director			43,000	43,000		43,000		43,000		9
10	Nursing and Medical Records	1,039,855	73,421	2,971	1,116,247	2,490	1,118,737	(15,240)	1,103,497		10
10a	Therapy	23,779			23,779		23,779		23,779		10a
11	Activities	71,394	1,877	1,536	74,807	99	74,906		74,906		11
12	Social Services	43,268			43,268		43,268		43,268		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,178,296	75,298	47,507	1,301,101	2,589	1,303,690	(15,240)	1,288,450		16
	C. General Administration										
17	Administrative	110,538			110,538		110,538		110,538		17
18	Directors Fees										18
19	Professional Services			459,642	459,642	(14,316)	445,326	(437,065)	8,261		19
20	Dues, Fees, Subscriptions & Promotions			47,268	47,268	(5,328)	41,940	(36,223)	5,717		20
21	Clerical & General Office Expenses	316,189	19,101	157,149	492,439	5,380	497,819	25,029	522,848		21
22	Employee Benefits & Payroll Taxes			265,325	265,325	19,646	284,971	31,979	316,950		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,281	4,281		4,281	4,616	8,897		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			28,797	28,797		28,797	7,137	35,934		26
27	Other (specify):* Bad debt			29,106	29,106		29,106	(29,106)			27
28	TOTAL General Administration	426,727	19,101	991,568	1,437,396	5,382	1,442,778	(433,633)	1,009,145		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,150,127	293,078	1,264,715	3,707,920	(12,905)	3,695,015	(446,954)	3,248,061		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alden Estates of Evanston

#0040733

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					29,202	29,202	182,667	211,869			30
31	Amortization of Pre-Op. & Org.							8,075	8,075			31
32	Interest			301,943	301,943		301,943	361,236	663,179			32
33	Real Estate Taxes					14,316	14,316	167,272	181,588			33
34	Rent-Facility & Grounds			955,434	955,434		955,434	(955,191)	243			34
35	Rent-Equipment & Vehicles			7,484	7,484		7,484	6,868	14,352			35
36	Other (specify):* Mortg. Insurance			30,613	30,613	(30,613)		39,481	39,481			36
37	TOTAL Ownership			1,295,474	1,295,474	12,905	1,308,379	(189,592)	1,118,787			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		321,921	520,542	842,463		842,463	(124,902)	717,561			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		73		73		73	(73)	0			41
42	Provider Participation Fee			22,995	22,995		22,995		22,995			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		321,994	543,537	865,531		865,531	(124,975)	740,556			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,150,127	615,072	3,103,726	5,868,925		5,868,925	(761,521)	5,107,404			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,491)	30		9
10	Interest and Other Investment Income	(293,082)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,077)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(195)	20		19
20	Contributions	(1,050)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(29,106)	27		24
25	Fund Raising, Advertising and Promotional	(31,483)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (381,484)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(329,110)		34
35	Other- Attach Schedule	(50,927)	pg 5a	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (380,037)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (761,521)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Estates of Evanston

ID# 0040733

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	BACK OUT: LEGAL FEES COLLECTIONS	\$ (9,596)	21	1
2	BACK OUT: HEALTHCARE ASSOC PAC FEES	(280)	20	2
3	BACK OUT: CLOTHING / GIFT SHOP ITEMS	(73)	41	3
4	BACK OUT MARKETING CONSULTANT	(2,470)	20	4
5	BACK OUT SKYLINE VALET	(35,000)	19	5
6	BACK OUT UTILITY LATE FEES	(4,273)	5	6
7	Record add'l def maint exp to correct amt.	1,522	6	7
8	Adj deprec exp to correct amount	143	30	8
9	back out Evanston chamber of commerce	(900)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(50,927)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,077)	0	0	4,915	0	0	0	0	0	0	0	(162)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,273)	0	1,322	0	0	0	0	0	0	0	0	(2,951)	5
6	Maintenance	1,522	0	3,522	0	0	0	(12)	0	0	0	0	5,032	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,828)	0	4,844	4,915	0	0	(12)	0	0	0	0	1,919	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(14,402)	(838)	0	0	0	0	0	0	(15,240)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	(14,402)	(838)	0	0	0	0	0	0	(15,240)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(35,000)	4,606	(406,671)	0	0	0	0	0	0	0	0	(437,065)	19
20	Fees, Subscriptions & Promotions	(36,378)	0	155	0	0	0	0	0	0	0	0	(36,223)	20
21	Clerical & General Office Expenses	(9,596)	0	9,630	15,955	9,040	0	0	0	0	0	0	25,029	21
22	Employee Benefits & Payroll Taxes	0	0	30,540	0	1,439	0	0	0	0	0	0	31,979	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	4,616	0	0	0	0	0	0	0	0	4,616	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,137	0	0	0	0	0	0	0	0	0	7,137	26
27	Other (specify):*	(29,106)	0	0	0	0	0	0	0	0	0	0	(29,106)	27
28	TOTAL General Administration	(110,080)	11,743	(361,730)	15,955	10,479	0	0	0	0	0	0	(433,633)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,908)	11,743	(356,886)	6,468	9,641	0	(12)	0	0	0	0	(446,954)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(21,348)	189,541	12,564	0	1,910	0	0	0	0	0	0	182,667 30
31	Amortization of Pre-Op. & Org.	0	7,431	578	0	0	66	0	0	0	0	0	8,075 31
32	Interest	(293,082)	633,869	18,024	0	1,505	920	0	0	0	0	0	361,236 32
33	Real Estate Taxes	0	165,257	1,548	0	467	0	0	0	0	0	0	167,272 33
34	Rent-Facility & Grounds	0	(955,434)	243	0	0	0	0	0	0	0	0	(955,191) 34
35	Rent-Equipment & Vehicles	0	0	6,868	0	0	0	0	0	0	0	0	6,868 35
36	Other (specify):*	0	39,481	0	0	0	0	0	0	0	0	0	39,481 36
37	TOTAL Ownership	(314,430)	80,145	39,825	0	3,882	986	0	0	0	0	0	(189,592) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(24,285)	(59,633)	(40,984)	0	0	0	0	0	(124,902) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(73)	0	0	0	0	0	0	0	0	0	0	(73) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(73)	0	0	(24,285)	(59,633)	(40,984)	0	0	0	0	0	(124,975) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(432,411)	91,888	(317,061)	(17,817)	(46,110)	(39,998)	(12)	0	0	0	0	(761,521) 45

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See page 6k		See page 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent	\$ 955,434	Alden Estates of Evanston II, Inc.	100.00%	\$	\$ (955,434)
2	V	32 Investments -RR	880	Alden Estates of Evanston II, Inc.			(880)
3	V	19 Audit		Alden Estates of Evanston II, Inc.		3,700	3,700
4	V	19 Professional fees		Alden Estates of Evanston II, Inc.		750	750
5	V	19 Misc. expenses		Alden Estates of Evanston II, Inc.		156	156
6	V	33 Real estate taxes		Alden Estates of Evanston II, Inc.		165,257	165,257
7	V	26 Property & liability insurance		Alden Estates of Evanston II, Inc.		7,137	7,137
8	V	32 Interest on mortgage payable		Alden Estates of Evanston II, Inc.		634,749	634,749
9	V	36 Mortgage insurance premium		Alden Estates of Evanston II, Inc.		39,481	39,481
10	V	30 Depreciation		Alden Estates of Evanston II, Inc.		189,541	189,541
11	V	31 Amortization		Alden Estates of Evanston II, Inc.		7,431	7,431
12	V						
13	V						
14	Total		\$ 956,314			\$ 1,048,202	\$ * 91,888

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 employee benefits	\$	Alden Management Services	100.00%	\$ 30,540	\$ 30,540	15
16	V	19 profess. Fees	410,922	Alden Management Services		4,251	(406,671)	16
17	V	21 g & a		Alden Management Services		9,630	9,630	17
18	V	5 utilities		Alden Management Services		1,322	1,322	18
19	V	6 maintenance		Alden Management Services		3,522	3,522	19
20	V	24 auto/travel		Alden Management Services		4,616	4,616	20
21	V	20 subscriptions/etc		Alden Management Services		155	155	21
22	V	30 depreciation		Alden Management Services		12,564	12,564	22
23	V	31 amortization		Alden Management Services		578	578	23
24	V	33 real estate tax		Alden Management Services		1,548	1,548	24
25	V	34 rent		Alden Management Services		243	243	25
26	V	35 rent-equip/vehicles		Alden Management Services		6,868	6,868	26
27	V	32 interest		Alden Management Services		18,024	18,024	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 410,922			\$ 93,861	\$ * (317,061)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Tube feeding	\$ 173	Pyramid Health Care Services	100.00%	\$ 5,088	\$ 4,915	15
16	V	10 Nursing supplies	16,204	Pyramid Health Care Services		1,802	(14,402)	16
17	V	39 Per diem/other supplies	59,232	Pyramid Health Care Services		34,947	(24,285)	17
18	V	21 General & admin		Pyramid Health Care Services		15,955	15,955	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 75,609			\$ 57,792	\$ * (17,817)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Drugs	\$ 158,805	Forum Extended Care II	100.00%	\$ 121,745	\$ (37,060)	15
16	V	10 House stock	3,594	Forum Extended Care II		2,756	(838)	16
17	V	39 IV	96,731	Forum Extended Care II		74,158	(22,573)	17
18	V	22 Employee benefits		Forum Extended Care II		1,439	1,439	18
19	V	21 G & A		Forum Extended Care II		9,040	9,040	19
20	V	32 Interest		Forum Extended Care II		1,505	1,505	20
21	V	33 Real estate taxes		Forum Extended Care II		467	467	21
22	V	30 Depreciation		Forum Extended Care II		1,910	1,910	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 259,130			\$ 213,020	\$ * (46,110)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Therapy	\$ 516,369	Community physical Therapy	100.00%	\$ 475,385	\$ (40,984)	15
16	V	32 Interest		Community physical Therapy		920	920	16
17	V	31 Amortization		Community physical Therapy		66	66	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 516,369			\$ 476,371	\$ * (39,998)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 maintenance expense	\$ 3,794	Alden Bennett Construction	100.00%	\$ 3,782	\$ (12)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 3,794			\$ 3,782	\$ *	(12) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Estates of Evanston # 0040733 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlosberg a.	President	CEO	100.00	355,821	0.812	2.03	SALARY	\$ 7,391	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin		89,846	0.812	2.03	SALARY	1,866	17-1	2
3	Terry Magnusson c.	Maint. Supervisor	constuct/maint		84,070	0.812	2.03	SALARY	1,746	17-1	3
4											4
5											5
6											6
7	a. Floyd Schlosssberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg.										9
10											10
11											11
12											12
13								TOTAL	\$ 11,003		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Estates of Evanston # 0040733 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson Ave.
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 286-3883
 Fax Number (773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see page 8A (also on page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$		1					
2	Cambridge		X	Operations	Varies	4/00	8,000,800	7,881,965	05/2035	8.0300	634,749	2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Related Party - AMS	X		Working capital							27,154	6							
7		X		Working capital							1,505	7							
8	Related party - CPT	X		Working capital							920	8							
9	TOTAL Facility Related							\$ 8,000,800	\$ 7,881,965			\$ 664,328	9						
	B. Non-Facility Related*																		
10	Offset interest income with interest expense											(1,149)	10						
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$				\$ (1,149)	14						
15	TOTALS (line 9+line14)							\$ 8,000,800	\$ 7,881,965			\$ 663,179	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,491 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Alden Estates of Evanston

0040733 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	227,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	193,457	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(34,043)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	199,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	14,316	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	179,573	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997 125,489 8			
		1998 203,750 9			
		1999 215,336 10			
		2000 220,724 11			
		2001 193,457 12			
Accrual based on 3% increase over prior year.					

		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Estates of Evanston COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040733

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-280-3883 FAX #: 773-286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-10-200-077-0000</u>	<u>Nursing Home Facility</u>	\$ <u>193,457.11</u>	\$ <u>193,457.11</u>
2. _____	<u>Related Party - Alden Management</u>	\$ <u>76,052.00</u>	\$ <u>1,548.00</u>
3. _____	<u>Related Party - Forum</u>	\$ <u>8,608.00</u>	\$ <u>467.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>278,117.11</u></u>	\$ <u><u>195,472.11</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
53,567

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
☐ NO

If so, please complete the following:

1. Total Amount Incurred:
260,098

2. Number of Years Over Which it is Being Amortized:
35

3. Current Period Amortization:
7,431

4. Dates Incurred:
3/31/95

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF/Assisted living	53,277	1995	\$ 350,000	1
2					2
3	TOTALS	53,277		\$ 350,000	3

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	\$ 18,359	\$	22	\$		\$ 18,359	4
5	99		1995	1994	5,377,512	159,376	39	137,885	(21,491)	1,073,665	5
6	Reclass Refinancing fees		1999		54,450	1,601	34	1,601		4,804	6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Repair: boiler, valve, elect. Fixtures, heater, TV antenna	1995	\$ 17,311	\$ 1,330	10-20	\$ 1,330	\$	\$ 9,722		37
38	Install lawn sprinkler system	1996	19,670	1,311	15	1,311		8,343		38
39	Demolition, excavating, electricalwork, masonry	1996	39,481	2,715	25	2,715		14,677		39
40	Sign	1996	745	62	12	62		383		40
41	Sink	1996	1,366	68	20	68		450		41
42	Motor repair	1996	3,300	165	20	165		1,155		42
43	Elevator remodeling	1996	3,018	151	20	151		943		43
44	Install new electrical outlets	1997	2,542		5			2,542		44
45	Telephone system upgrade	1997	2,698	270	10	270		1,371		45
46	Repair panel	1998	3,631	726	5	726		3,450		46
47	Repair rainshields, relief valve	1998	7,117	712	10	712		3,262		47
48	Replace fan motor	1998	5,797	1,159	5	1,159		5,314		48
49	Electrical panel	1998	1,926	193	10	193		835		49
50	Replace freezer compressor	1998	3,457	346	10	346		1,498		50
51	Replace fire alarm sys	1998	56,459	3,764	15	3,764		15,997		51
52	Elm heating-cooler-hvac	1999	2,500	250	10	250		875		52
53	Aqua plumbing-water heater	1999	10,445	696	15	696		2,205		53
54	CSI-repair air maint. Handler unit	1999	1,855	185	10	185		711		54
55	New horizons-hook up phones	1999	1,827	183	10	183		655		55
56	Alden Bennett Const.	2000	7,160	716	10	716		2,148		56
57	The floor source-lobby & elevator carpeting	2000	3,652	730	5	730		2,069		57
58	Alden Bennett Const.-wallcovering	2000	1,350	270	5	270		765		58
59	DBS Contracting-repair lawn sprinkler	2000	2,281	228	10	228		570		59
60	CSI-install disposal	2000	2,341	468	5	468		1,131		60
61	Forx valley fire & safety-repair sprinkler system	2000	1,765	118	15	118		284		61
62	CSI-replace compressor	2000	1,770	177	10	177		428		62
63	Alden Bennett-seca/stripe parking lot, replace sidewalk	2000	5,582	625	5-15	625		1,470		63
64	Service on Elliot Will -CSI Coker	2001	5,205	521	10	521		521		64
65	Capps plumbing repair for meter bypass line	2001	1,840	368	5	368		368		65
66	The floor source - lobby & elevator carpet	2001	944	189	5	189		189		66
67	Sonja	2002	2,227		10					67
68	ABC (amtech lighting)	2002	2,202	18	20	18		18		68
69	New Horizon (replace main frame)	2002	1,745	204	5	204		204		69
70	TOTAL (lines 4 thru 69)		\$ 5,675,530	\$ 179,895		\$ 158,404	\$ (21,491)	\$ 1,181,379		70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,675,530	\$ 179,895		\$ 158,404	\$ (21,491)	\$ 1,181,379	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,334	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	344	40	344		183	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,732,104	\$ 182,045		\$ 160,554	\$ (21,491)	\$ 1,227,486	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 559,095	\$ 44,783	\$ 44,783	\$	VARIOUS	\$ 143,840	71
72	Current Year Purchases	31,892	2,017	2,017		VARIOUS	2,017	72
73	Fully Depreciated Assets	70,851	723	723		VARIOUS	70,851	73
74								74
75	TOTALS	\$ 661,838	\$ 47,523	\$ 47,523	\$		\$ 216,708	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CAR/ENGINE/BUS/VAN	DODGE	98-'02	\$ 12,336	\$ 3,792	\$ 3,792	\$	3	\$ 9,992	76
77										77
78										78
79										79
80	TOTALS			\$ 12,336	\$ 3,792	\$ 3,792	\$		\$ 9,992	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,756,279	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 233,360	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 211,869	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,491)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,454,187	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$ n/a	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party- cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 7,484

Description: copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>related party</u>		\$	\$ <u>6,868</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>6,868</u>	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>Skilled nurses on sight</u></p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 184,262
2	Licensed Speech and Language Development Therapist	39-3	hrs				19,065			19,065	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				305,629			305,629	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	see page 16a	# of prescrpts				82,717			82,717	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify):	see page 16a					125,888			125,888	13
14	TOTAL			\$		\$	717,561	\$		\$ 717,561	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 6,293	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 131,979)	874,065	874,065	3
4	Supply Inventory (priced at)	794	794	4
5	Short-Term Investments	3,417	353,268	5
6	Prepaid Insurance	545	545	6
7	Other Prepaid Expenses		18,560	7
8	Accounts Receivable (owners or related parties)		74,322	8
9	Other(specify): Due from IDPA	5,177	5,177	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 883,998	\$ 1,333,024	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		240,281	12
13	Land		980,000	13
14	Buildings, at Historical Cost		6,278,135	14
15	Leasehold Improvements, at Historical Cost	249,803	249,803	15
16	Equipment, at Historical Cost	140,824	569,274	16
17	Accumulated Depreciation (book methods)	(171,328)	(682,830)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 219,300	\$ 7,634,664	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,103,297	\$ 8,967,687	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 341,658	\$ 342,335	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	174,043	174,043	28
29	Short-Term Notes Payable	76,877	129,890	29
30	Accrued Salaries Payable	133,453	133,453	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,303	27,303	31
32	Accrued Real Estate Taxes(Sch.IX-B)		199,300	32
33	Accrued Interest Payable		52,743	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses/ due to BBS	59,614	68,509	36
37	Due to affiliates	4,590,396	4,590,396	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,403,343	\$ 5,717,971	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	201,522	8,030,474	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 201,522	\$ 8,030,474	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,604,866	\$ 13,748,446	46
47	TOTAL EQUITY (page 18, line 24)	\$ (4,501,569)	\$ (4,780,759)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,103,297	\$ 8,967,687	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,879,623)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2001 cost report was		3
4	submitted. These have no effect on prior years report:		4
5	Bad debt, medicare revenue	158,954	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,720,669)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(780,900)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (780,900)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,501,569)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,746,145	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,746,145	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	88,787	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 88,787	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Recovery of Bad debt</u>	4,295	28
28a	<u>Miscellaneous income</u>	4,763	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,058	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,843,990	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	969,423	31
32	Health Care	1,301,101	32
33	General Administration	1,437,396	33
B. Capital Expense			
34	Ownership	1,295,474	34
C. Ancillary Expense			
35	Special Cost Centers	842,536	35
36	Provider Participation Fee	22,995	36
D. Other Expenses (specify):			
37	<u>Related party salary allocations</u>	(244,035)	37
38	<u>transactions not included on this page, but included</u>		38
39	<u>on page 3&4.</u>		39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,624,890	40
41	Income before Income Taxes (line 30 minus line 40)**	(780,900)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (780,900)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,487	1,511	\$ 53,839	\$ 35.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,311	14,795	368,096	24.88	3
4	Licensed Practical Nurses	8,868	9,619	205,483	21.36	4
5	Nurse Aides & Orderlies	32,335	33,436	350,790	10.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,971	3,114	33,847	10.87	9
10	Activity Assistants	3,812	4,010	40,629	10.13	10
11	Social Service Workers	1,944	2,080	43,268	20.80	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,080	33,682	16.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,013	31,611	340,480	10.77	15
16	Dishwashers					16
17	Maintenance Workers	1,872	2,056	42,482	20.66	17
18	Housekeepers	11,165	11,942	84,332	7.06	18
19	Laundry	3,413	3,644	37,154	10.20	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	8,136	8,437	162,601	19.27	22
23	Office Manager					23
24	Clerical	3,176	3,280	50,569	15.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,865	1,974	58,840	29.81	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,296	133,589	\$ 1,906,092 *	\$ 14.27	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	43,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,376	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,524	11-3	44
45	Social Service Consultant		12	11-	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	28	\$ 46,912		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ n/a		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Alden Estates of Evanston

0040733

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description	Amount	Description	Amount		
Gerber, L.	Administrator	0	10,112	Workers' Compensation Insurance	\$ 40,280	IDPH License Fee	\$		
Gotesman, M	Administrator	0	60,000	Unemployment Compensation Insurance	12,705	Advertising: Employee Recruitment			
				FICA Taxes	148,931	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	54,213	Surety bond fees, dues & subscriptions	655		
				Employee Meals	24,910	IL Health Care Assoc	4,796		
Executive Management	Administrator	0	40,426	Illinois Municipal Retirement Fund (IMRF)*		Employee Assoc. Due	111		
TOTAL (agree to Schedule V, line 17, col. 1)				Related party - FecII	1,439				
(List each licensed administrator separately.)			\$ 110,538	dental, life, pension costs	910				
B. Administrative - Other				relations, miscell, & background chks	787				
Description			Amount	drug test, 401k match, vaccinations, dishonesty	2,233	Related party-Ams	155		
			\$	RELATED PARTY-AMS	30,540	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 316,950	TOTAL (agree to Sch. V, line 20, col. 8)			
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type						Out-of-State Travel	\$	
Alden Management Services	MNGT. FEES		410,922						
BDO	ACCT. FEES		12,528				In-State Travel		
Ken Fisch/Greenburg/Hermann	Legal Fees		20,266				misc/gas/repairs	2,045	
Medicom	Software consultant		166				Related party-Ams	4,616	
Talx Corp	Work comp consulting		440				Seminar Expense		
US Gas & Energy	Utilities		891				IL Healthcare Assoc./Comprehensive Therap	950	
Mayer Brown & Platt	Consulting fee		14,316				O.C.C./Life Serv. Network	470	
Various	Misc.		114				Other	816	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 459,642				TOTAL	\$ 8,897	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting	6/95	\$ 2,000	3	\$	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting	1/96	448	3									
3	Painting	2/96	450	3	12								
4	Painting	4/96	453	3	38								
5	Painting	5/96	454	3	51								
6	Painting	6/96	464	3	64								
7	Painting	7/96	920	3									
8	Painting	9/96	1,969	3	438								
9	Painting	11/96	491	3	136								
10	Painting	12/96	469	3	144								
11	Plumbing repairs	11/96	1,897	15	125	126	126	126	126	126	126	126	126
12	A/C repairs	6/97	1,720	3	573	240							
13	Painting	9/00	3,856	3		428	1,285	1,285	858				
14	Painting	11/02	5,491	3				305	1,830	1,830	1,526		
15	Painting	11/02	3,511	3				195	1,171	1,171	974		
16	Painting	1-12/98	7,231	3	2,410	2,410	1,218						
17	Painting>1,500 ytd 1999	7/99	6,140	3	1,023	2,047	2,047	1,023					
18													
19													
20	TOTALS		\$ 37,964		\$ 5,014	\$ 5,251	\$ 4,676	\$ 2,934	\$ 3,985	\$ 3,127	\$ 2,626	\$ 126	\$ 126

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Healthcare Assoc. \$4796
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,208 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ _____
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 24,910 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: BDO Seidman, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet issued
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.